C+D
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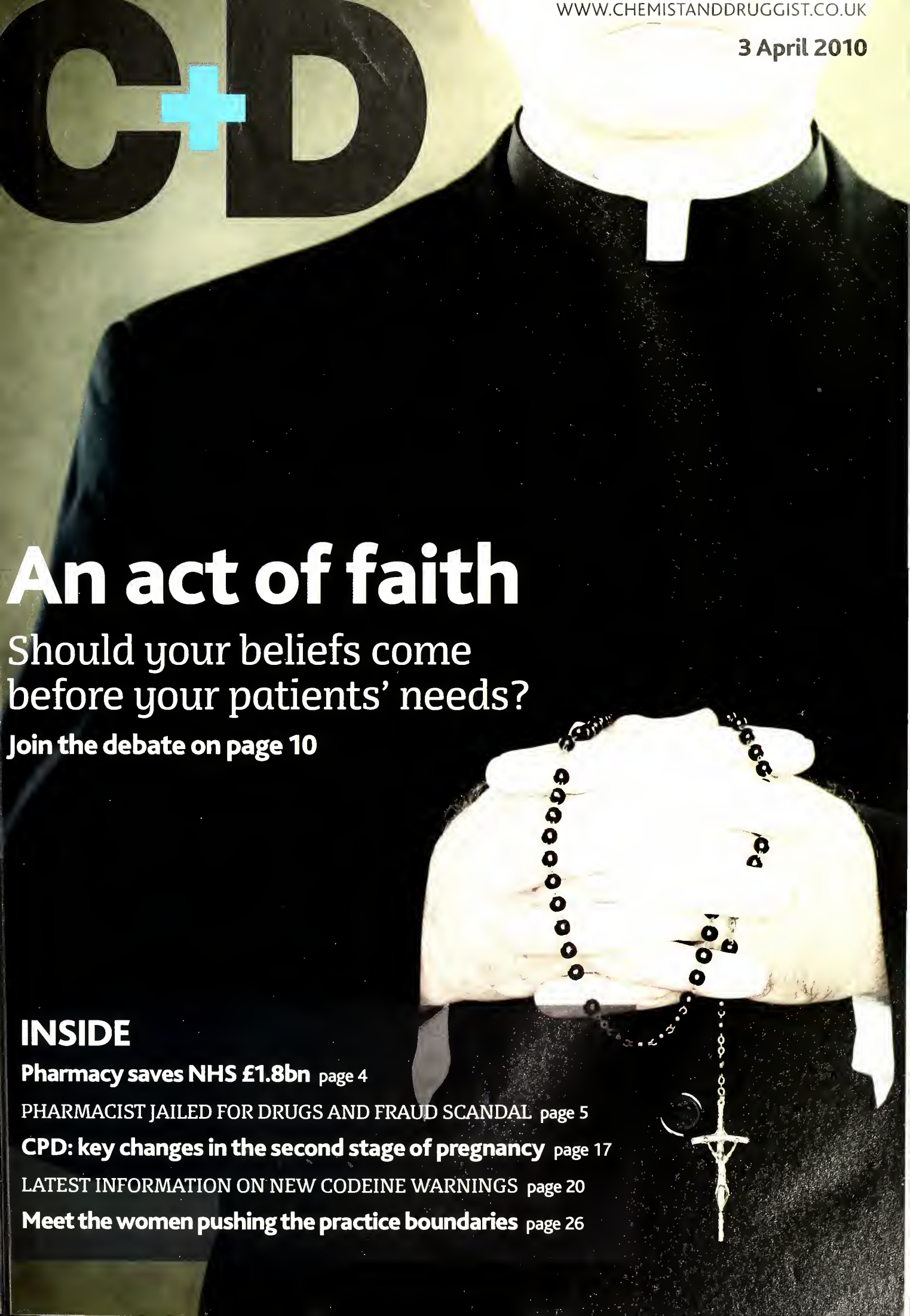
3 April 2010

An act of faith

Should your beliefs come before your patients' needs?

Join the debate on page 10



INSIDE

Get smokers off to a great start with NICORETTE® INVISI 25mg PATCH™

nicotine

- Significantly more smokers were abstinent during week 1 with NICORETTE® INVISI 25mg PATCH™ compared with our previous patch programme ($p<0.01$)[1]
- 44% more effective at helping smokers quit compared with our previous patch programme at 12 weeks ($p<0.005$)[2,3]

Recommend NICORETTE® INVISI 25mg PATCH™– the second generation 16-hour patch

NICORETTE® INVISIPATCH™ Product Information: Presentation: Transdermal delivery system available in 3 sizes (22.5, 13.5 and 9cm²) releasing 25mg, 15mg and 10mg of nicotine respectively over 16 hours. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. **Dosage: Adults (over 18 years):** Patients should stop smoking during treatment. The patch should be applied to the skin on the hip, upper arm or chest in the morning and removed at bedtime. Application should be limited to 16 hours per day. Most smokers are recommended to start on 25mg patch, applying one 25mg patch daily initially. In patients who successfully abstain in 8 weeks, dose should then be reduced to 15mg for 2 weeks and then 10mg for a further 2 weeks. Lighter smokers (smoking less than 10 cigarettes per day) are recommended to start at step 2 (15mg) for 8 weeks and then to decrease to 10mg for the final 4 weeks. Adults who use NRT beyond 9 months should seek advice from a healthcare professional. See SPC for further details. **Adolescents (12 to 18 years):** As per adults, but duration of therapy should not exceed 12 weeks without consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Unstable cardiovascular disease, diabetes mellitus, phaeochromocytoma or uncontrolled hyperthyroidism, renal or hepatic impairment, generalised dermatological disorders. Erythema may occur. If severe or persistent, discontinue treatment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Erythema, itching, urticaria, headache, nausea, vomiting, GI discomfort, dizziness, palpitations, reversible atrial fibrillation. See SPC for further details. **RRP (ex VAT):** 25mg packs of 7: (£14.83); 15mg packs of 7: (£14.83); 10mg packs of 7: (£14.83). **Legal category:** GSL. **PL holder:** McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **PL numbers:** 15513/0161; 15513/0160; 15513/0159. **Date of preparation:** December 2008.

References: 1. Data on file – CEASE 2. **2.** Tønnesen P. et al. Higher dosage nicotine patches increase one-year smoking cessation rates: results from the European CEASE trial. Eur Resp J 1999; 13:238-246. **3.** Data on file – CEASE 3.

Date of Preparation: March 2010 05546

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> FINANCIALLY, THE SECTOR HAS FACED CONSIDERABLE UPHEAVAL, BUT PROFESSIONALLY PHARMACY HAS SEEN A SEISMIC SHIFT

As I'm about to start this column, I can hear one of C+D's news team on the phone interviewing England's pharmacy minister Mike O'Brien about Labour's plans for community pharmacy should he still be in power after the election.

It's got me thinking – with just weeks to go until polling day, just how would you rate Labour's impact on community pharmacy? It's easy to focus on the negatives – after all, who doesn't like a good moan – but how should we judge the government's pharmacy team?

There's nothing like the here and now and so I'd suggest this week's news pages provide a pretty good barometer of how pharmacy has fared under Labour.

To kick off, the National Audit Office's finding that England's community pharmacists have saved the NHS £1.8 billion in four years (p4) is a good indicator of pharmacy's financial benefits. Add in the 8 per cent productivity gain and you can see just how efficient community pharmacy is.

However, the NAO's recommendation that PSNC be replaced by an independent organisation for future reviews of purchase profits is one that Mr O'Brien must kick into touch.

Pharmacy funding is a complex model – feel free to browse the Drug Tariff if you have any doubts – and if you want to see what happens when an independent body gets involved, have a look at the news that contractors are to get a £1,000 payment to compensate them for errors made by the NHS Business Services Authority's script pricing technology (p5).

Despite this latest payment, PSNC chief executive Sue Sharpe says she still has a "number of concerns" about the system. Room for improvement, minister.

But it's not all bad. The Department of Health's support for a national framework for healthy living pharmacies is a welcome boost (p4). It's been two years since the landmark white paper for pharmacy in England, which first mooted this development, was unveiled and pharmacists can justifiably claim that progress has been slower than they had hoped, but the direction of travel is still clear. As the APPG's chairman Howard Stoate says (p8), delivery just needs to go "further and faster".

Financially, there is no doubt that the sector has faced considerable upheaval and pain but, professionally at least, pharmacy has seen a seismic shift. Linda Hirst and Marta Hildebrandt's story of becoming England's first accredited Pharmacists with Special Interests is one that didn't exist a decade ago (p26). They are demonstrating just how valuable a contribution community pharmacists can make to the care of their patients.

It's not been easy financially for pharmacy under Labour, but that shouldn't mean we treat the significant professional progress the sector has made lightly.

Gary Paragpuri, Editor

Pharmacy has saved NHS £1.8bn since 2005, national audit reveals

But DH still allowed contractors to exceed agreed purchase profit, says spending watchdog

Jennifer Richardson
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England's community pharmacy contract has saved the NHS £1.8 billion in the four years since its introduction, the public spending watchdog has said.

And pharmacists have made indirect savings by increasing their dispensing productivity by 8 per cent while also delivering new services, the National Audit Office (NAO) added in a report on the contract published this week.

The NAO noted that excess purchase profits of £1.1bn were made by pharmacists between 2005-06 and 2008-09, above the agreed margin of £500 million per year. Better management of this by the Department of Health (DH) could have resulted in further savings to the health service, the NAO suggested.

PSNC chief executive Sue Sharpe said the excess margin must be seen in context with the fact that purchase profit potential had incentivised pharmacists to drive bargains with medicines suppliers, pushing down market prices. This was "intrinsically linked" to the £1.8bn savings the contract had made the NHS, she explained.

The NAO also questioned the robustness of the £500m target and whether it would have been possible to achieve "without threatening the viability of some pharmacies". Meeting the target would have required cutting spending on community pharmacy services by a quarter (£2.75bn) over the four years, the NAO explained.

The DH came under fire from the watchdog for not making a realistic assessment of pharmacies' level of purchase profits in the early days of the contract. The DH said it was "pleased" with the savings findings and productivity gains, and pledged to "consider the NAO's recommendations and take these into account as we further develop the arrangements for community pharmacy and the retained medicines margin".

Mrs Sharpe told C+D: "There is a strong business case for the NHS to increase investment in pharmacy services, and we will deliver this message as funding negotiations continue and we consider the results of the joint cost of service inquiry."

NAO: strip PSNC of survey role

The purchase profits margins survey should be carried out by an independent organisation rather than PSNC, the public spending watchdog has recommended.

The transfer of the evaluation of contractor invoices to determine purchase profits from the pharmacy contract negotiator to an independent body would remove "potential or perceived conflict of interest", the National Audit Office (NAO) said in a report published this week.

PSNC chief executive Sue Sharpe responded that the survey must be "transparent", regardless of its implementer. "The Department [of Health] has had full and unrestricted access to PSNC's work in conducting the survey, and have testified to the expertise and professionalism with which it has been administered," she said. **JR**

PHARMACY WHITE PAPER 2 YEARS ON

Boost for Healthy Living pilot

A national framework for healthy living pharmacies (HLP) is one step closer to realisation after a pilot scheme received backing from the Department of Health (DH).

The NHS Portsmouth pilot, which has seen 22 out of 38 pharmacies in the city sign up to the HLP scheme, will now inform a national framework after it was ratified by the Public Health Leadership Forum for Pharmacy.

The Healthy Living Pharmacy (HLP) initiative outlines how pharmacies in the PCT are expected to develop, creating a tier-based approach to service commissioning.

The national framework was still a "work in progress" and details were still being developed, said NHS Portsmouth HLP lead Deborah Evans. However, Ms Evans said that the Portsmouth model would "significantly inform" the national framework, which would focus on local health needs and improve commissioning of services.

The scheme had already paid dividends in Portsmouth, Ms Evans said. Portsmouth City PCT had specified patients with respiratory problems as a target for MURs, and encouraged GPs to refer patients to pharmacies. Over six weeks, 125 patients received a respiratory MUR across 15 pharmacies. Eight out of 10 patients had shown poor control and a third were smokers, demonstrating the initiative had reached its target audience, Ms Evans said.

The next stage for the Portsmouth pilot would be official accreditation of pharmacies as HLPs, scheduled for June 8, Ms Evans added.

The HLP initiative follows the aim for pharmacies to become 'healthy living centres', as set out in the pharmacy white paper published two years ago. **CC**

Deborah Evans: national framework being developed

"We need a more unified approach to rollout"

John D'Arcy and other industry chiefs judge the white paper: two years on www.chemistanddruggist.co.uk

'Murky double life' leads to three-year jail term

RPSGB fellow guilty of £140k fraud and possessing illegal drugs

An MBE-honoured pharmacist has been jailed for defrauding over £140,000 from taxpayers and possessing a cocktail of illegal drugs at his "sexual bondage" flat.

Charles Butler, a former chairman of the College of Pharmacy Practice (CPP), was sentenced to three years at Southwark Crown Court this week.

Professor Butler filed false expense claims for locum cover for nearly seven years, the court heard.

The offences took place while he was a paid expert on the Parliamentary and Health Service Ombudsman (PHSO) – a government quango that investigates NHS complaints.

Professor Butler, also an RPSGB fellow, billed the Health Services Commission for staff costs, despite selling off his pharmacy chain in 2002.

Passing sentence, Judge Michael Gledhill QC told professor Butler: "You were employed on behalf of the public to provide expert advice over a number of years. Your claiming of expenses for employment of a non-existent locum was a gross breach of trust."

When police raided professor Butler's flat at Whitechapel, East London in March last year they found a "cache of drugs" including cocaine, crystal meth, ecstasy and Rohypnol.

The flat was the "sordid" venue for professor Butler's "murky double life", the court heard. Prosecutor Deanna Heer told the court: "The address was specifically adapted to be used as a sexual bondage venue."

Professor Butler pleaded guilty to fraud between July 2002 and January 2009. He claimed poor pay had triggered his fraud offence. The £300 daily fee he received for expert consultancy to the PHSO was insufficient, he claimed.

Defending, Jeremy Lynn said: "He sought to justify the behaviour for himself. The amount he was paid was not enormous, he worked for longer hours than he was paid for."

Professor Butler received two and a half years for the fraud, plus six months consecutive for drug offences and was ordered to pay £141,893 compensation.

He has written an explanatory letter to his wife and five children, the court heard. **UKL**

Charles Butler: defrauded more than £140,000 from the government

Colleagues 'shocked and saddened'

Colleagues of Charles Butler have expressed shock and distress at the pharmacy professor's fall from grace. Ian Simpson, chief executive of the CPP, of which professor Butler was one of the founder members in 1981, told C+D: "We were totally shocked and very sad."

Professor Butler has not worked for the CPP since 2007, Mr Simpson added. There was no suggestion the CPP was involved in professor Butler's illegal activities, he stressed.

"Mr Butler was held in high esteem. We are deeply saddened that his distinguished career should end in such an ignominious way," Mr Simpson added.

Professor Butler is now set to face disciplinary proceedings by the RPSGB. The Society had been kept in the dark over criminal proceedings against the pharmacist, C+D was told. However, the regulator had "opened a file" into the disgraced former pharmacy owner. **MG**

£1k for pricing errors

Pharmacies will each receive £1,000 this summer to compensate for errors by NHS paymasters, PSNC has announced.

The payment will be made to all pharmacies that have had their prescriptions priced through the NHS Business Services Authority's (NHSBSA's) automated system, and were open on October 1, 2008, March 31, 2009, and April 1, 2010.

The cash was "to acknowledge difficulties experienced with the prescription pricing technology known as CIP", PSNC said, and follows a £3.5 million compensation deal negotiated in 2008.

The payment sparked mixed reactions from pharmacists who have encountered prescription pricing problems. Day Lewis area support manager Pam Cook said: "It's brilliant that they are recognising the difficulties."

However, Nisheet Cokeham, of Cokeham Pharmacy, Sompting, was unconvinced the compensation was sufficient and called on PSNC to reveal details of how the amount was negotiated. **JR**

NPA jobs cuts revealed

The NPA has announced up to four job cuts as part of a restructuring process.

The association said it was consulting on proposals that affected one NPA department.

When asked what had triggered the redundancies, an NPA spokesperson said: "The NPA is doing fine as a business, but it is normal business practice to review structure to make sure you move forward." **MG**

In brief

RPSGB hits back

The RPSGB did not carry out research behind the widely criticised GPhC standards, the Society's CEO has told C+D. The work was down to the DH on behalf of the GPhC, Jeremy Holmes stressed. The comments come after GPhC chair Bob Nicholls said the RPSGB and DH drew up the proposals (C+D, March 27, p10).

Generic substitution

The public consultation on government plans to allow pharmacists to dispense generics against prescriptions for branded medicines has closed. The DH said it would respond "in due course".

Commissioning report

Many PCTs believe they are working effectively, but evidence suggests otherwise, MPs have said in a report on commissioning published this week. PCTs lacked the necessary skills, including clinical knowledge, data analysis and management, said the parliamentary health committee.
www.chemistanddruggist.co.uk

Prescription charge

The prescription charge per item for England and Wales has been frozen at £7.20 for 2010-11, health minister Mike O'Brien has said. Pre-payment certificate costs also remain the same. There have been no changes to patient exemptions.
www.chemistanddruggist.co.uk

MHRA recalls

The MHRA has issued three drug recalls: unused stocks of 32 medicines products supplied by Star Pharmaceuticals and PIE Pharma; a parallel-imported Landmark Pharma batch of timoptol 0.5% 5ml eye drops; and batches of clopidogrel 75mg in Ratiopharm and Sandoz livery.
www.mhra.gov.uk

Free script benefits

A report has shown that free prescriptions in Wales have increased equity and access to medicines for thousands of patients, with no unusual effect on script volumes and no evidence OTC medicines have been prescribed for people taking advantage of the exemption.

In brief

Joining fees may top £395

A pledge to cap the cost of joining the new pharmacy regulator and professional leadership body (PLB) at £395 may not be met. GPhC chair Bob Nicholls said: "I can't give any guarantees about that [meeting the £395 pledge]. We're going to base it on what we need to do as a regulator."
www.chemistanddruggist.co.uk

Chinese medicine alert

Nearly 1,000 packs of a potentially dangerous traditional Chinese medicine (TCM) are still circulating in the UK, the MHRA has warned. Concerns were raised about the unlicensed herbal product Jingzhi Kesou Tan Chuan Wan.
www.chemistanddruggist.co.uk

Beta-blockers study

Beta-blockers could reduce metastasis and mortality in patients with breast cancer, according to research from Nottingham University. The study suggests beta-blockers should be investigated as a supplementary therapy in breast cancer treatment.
www.chemistanddruggist.co.uk

Methadone service aid

The Scottish Government has offered help for local services struggling to meet increased demand for methadone treatment. It follows an outbreak of anthrax among drug users in Scotland, believed to have been caused by contaminated heroin.
www.chemistanddruggist.co.uk

CCA hits the road

The CCA has improved the support it offers its local pharmaceutical committee (LPC) representatives with the introduction of nine spring roadshows.
www.chemistanddruggist.co.uk

Aerosols caused fire

A fire at a Bolton pharmacy was caused by stock left too close to a heater, not an arson attack. Officials had believed that Sykes Chemist had been hit by an arson attack. However, an investigation confirmed the blaze had been caused by aerosols left by a heater.
www.chemistanddruggist.co.uk

Obesity chief: turn to pharmacy to solve crisis

GPs being paid to keep patients fat, says National Obesity Forum boss

Chris Chapman
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Pharmacists should be paid to manage obese patients, say GPs

The UK's system of tackling obesity is not fit for purpose with pharmacists needing to play a greater role to stop the obesity epidemic, leading GPs have warned.

Speaking at the Tackling Obesity 2010 conference last week, National Obesity Forum chair David Haslam said the GPs' QOF system rewarded doctors for keeping patients fat, not improving health.

He said: "With obesity in the QOF I'm incentivised to identify fat people and make a list of them, and with the list do absolutely nothing."

Speaking exclusively to C+D, Dr Haslam backed calls for a greater role for pharmacy in tackling obesity, hailing a nationally backed service as an initiative that would "pay more than lip service" to the problem.

Outlining his ideal service, Dr Haslam said he would like to see pharmacies keep a register of obese patients, and then receive points for testing blood glucose, blood pressure and cholesterol, allowing patients to move into a treatment cascade if required.

Conditions such as sleep apnoea and polycystic ovary syndrome could also be targeted and areas such as childhood obesity tackled, he suggested.

Dr Haslam's calls for wider involvement in obesity management were backed by BMA deputy chair Richard Vautrey, who warned that the problem was too big for GPs.

"General practice alone can't tackle the obesity epidemic, we need a joined-up approach," Dr Vautrey said.

When asked if he supported the use of OTC products, Dr Haslam said that while a service should be a weight management, rather than weight loss, programme, he was "fully supportive" of evidence-based OTC therapies, such as Alli.

Acne won't kill you, but obesity might... Terry Maguire wants the NHS to get its priorities right

See p14

C+D gets grassroots verdict on new BNF

C+D has put the new-look BNF to the test, after the latest design ditched several appendices in favour of including information in the relevant chapters.

The redesign, introduced in March 2010's BNF 59, adds information on prescribing for patients with hepatic or renal impairment, or who are pregnant and breastfeeding, within the relevant monograph. The other appendices remain unchanged.

The changes follow "good feedback" from the similar layout adopted in the BNF for Children, a spokesperson told C+D.

To test the new layout, C+D set Numark pre-registration pharmacist Moses Nutekpor, of Chrischem pharmacy, Mile End, two questions to answer, using both the old and new BNFs. To see how he got on with the new designs, go to www.chemistanddruggist.co.uk **CC**

Watch Moses Nutekpor test the new-look BNF

www.chemistanddruggist.co.uk

Swine flu faces DH review

The government has launched an independent review of the response to the swine flu pandemic, according to the Department of Health (DH).

The review comes as cases of swine flu dropped to their lowest level since the outbreak of the H1N1 virus last spring.

The review, which will report back to MPs before parliament's summer recess, will look at the response to the pandemic across all four home nations, the DH confirmed. It will be chaired by former Welsh chief medical officer Deirdre Hine.

Pharmacists were on the front line of the swine flu outbreak, with many pharmacies acting as distribution points for the antiviral Tamiflu.

There have been 457 deaths related to swine flu in the UK. **CC**

Dispensary talk

Have the control of entry exemptions led to better quality pharmacy services?

"I would say no, partly because it has diluted the overall funding available for community pharmacy, and also because of the clustering of 100-hour contracts. Some towns have eight or nine 100-hour pharmacies – do they really need that many?"
James Wood, director, Wicker Pharmacy, Sheffield

"While control of entry exemptions have resulted in more pharmacies than before, overall this hasn't benefited the patient at all. The dilution of the customer base means that pharmacies in general are not as busy as they were."
Phil Bullen, pharmacy proprietor, Wellness Pharmacy, Cardiff

Web verdict

Yes, service quality is better 17%

It's only increased access 42%

No, no patient benefits 10%

No, poorer quality services 31%

Armchair view: Relaxing control of entry has meant quantity but not quality of pharmacy services according to poll voters. Less, it seems, is more in this case.
This week's question: Is the pharmacy white paper marks second birthday, how well has it been delivered? Vote at www.chemistanddruggist.co.uk

Next government told to honour white paper

APPG policy plan reiterates reforms set out in 2008 document

PHARMACY WHITE PAPER 2 YEARS ON

Kathy Oxtoby
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APPG leaders have urged the DH to fast track pharmacy development

The all-party pharmacy group (APPG) has called on the next government to honour reforms set out in England's pharmacy white paper on the second anniversary of the landmark publication.

The APPG's Policy Action Plan sets out 12 priority tasks for the triumphant party at the impending general election.

Key targets include fast tracking the rollout of priority pharmacy services and placing safeguards on PCTs to ensure the pharmacy budget is not diverted or cut.

A QOF-style reward mechanism in future contracts and a nationally co-ordinated pharmacy PR campaign also feature in the plan.

While several recommendations have already featured in the white paper, APPG chair Howard Stoate said he wanted them to be implemented "further, and faster".

He told C+D: "We're going in the right direction but we're not going far enough.

"While there have been improvements in some places, in other areas things are too patchy and slow. We want to see all parts of the country move ahead with good speed."

The APPG plan echoes many of the recommendations from the group's Future of Pharmacy report published in 2007. Dr Stoate said having to repeatedly call for the same improvements was "frustrating for pharmacy".

The plan urges central government to play a greater role in commissioning pharmacy services – contrary to the push towards devolved decision making under recent policy.

Westminster must issue guidance and directions, including pharmacy service specifications, to PCTs to correct inconsistent commissioning, the APPG recommends.

The Department of Health should also fund more nationally agreed advanced services akin to MURs, according to the APPG. High priority services such as minor ailments, sexual health and managing chronic conditions are "too important" to be treated as enhanced local services, the document recommends.

Another action point centres on stock shortages that have plagued pharmacy since 2008. The APPG urged a DH-backed memorandum of understanding between the supply chain that would ban any exporting that compromised patient safety. Extra powers should be given to the UK drugs watchdog to tackle traders who flouted this agreement, the APPG added.

The group also urged mandatory pharmacy representation at PCT board level, incentives to improve medicine waste, and improved pharmacist access to the NHS Care Record.

APPG action plan: what the next government must do for pharmacy

1. Rollout high-priority pharmacy services.
2. Safeguard the pharmacy budget when it is devolved to PCT level to stop cash being diverted or cut.
3. Make minor ailments, sexual health and managing long-term conditions nationally funded advanced services.
4. Lead a campaign to raise awareness of community pharmacy services.
5. Launch a national first prescription service that would get pharmacists to manage patients with a newly diagnosed chronic condition.
6. Review progress on developing pharmacy within three months of taking power.

Should it be compulsory to dispense contraception?

As patients who are refused contraceptives by pharmacies receive national media attention, C+D asks whether pharmacists should be allowed to invoke the 'conscience clause'

says the National Secular Society president

We have been getting complaints from people all over the country saying they have been turned away from various pharmacies [without their prescribed contraception]. In almost all cases they say they have gone into a pharmacy and been told they can't have their prescription because of religious reasons.

Sometimes it's in a public area, perhaps with other people listening, so it's understandable that people would be annoyed and embarrassed about it. It's quite humiliating to be told in public that you can't have your contraceptive pills – people are shocked.

Pharmacists are providing a public service and sometimes there could be quite catastrophic effects if they refuse. For example, if people are living somewhere rural it could be difficult to find an alternative pharmacy. If they require EHC and it needs to be taken quickly, the effects could be far more than just feeling that pharmacists are judging them.

The public are outraged [about this] too so I think that the pharmacy regulator has really got to think about this a little more. People want to opt out of doing bits of their jobs but, when you're serving the public, you can't just pick and choose which bits of the service you are going to provide.

I would like to see the conscience clause removed. Maybe there could be a period of change and existing pharmacists could keep the clause because that's what they signed up to, but new pharmacists would have to accept the new conditions – they must do it [supply contraceptives] or not do the job.

The regulatory body would have to regulate this. If they changed the Code of Ethics to take this into account and there were pharmacists not abiding by the code they might have to discipline them. The code is not legally [enforced] so this would have to be regulated quite strictly.

says the RPSGB

If a pharmacist opts out of supplying contraception, we advise they must explain to patients that they cannot personally dispense the medicines because they have personal beliefs that prevent them from doing so. They should apologise and tell patients when they can return or direct them to another pharmacy.

They can't just say no, they have to offer an alternative service, and neither can they say they don't think the patient should take the medicine.

There can be misinterpretations, but a patient being refused the dispensing of contraception is not being judged, it's because the pharmacist is saying their personal beliefs don't allow them to dispense.

Patient reactions are probably split 50:50, but you don't tend to hear about the people who accept the situation. On a practical note we would hope any conscientious objections would be discussed with employers and that there would be an agreed approach to patient care. It's in everybody's interests for pharmacists to explain themselves to patients and to make sure they understand the reasons for the inability to dispense.

Pharmacists have lengthy training and dispensing medicines is just one way in which they help patients. If someone has a conscientious objection that affects one dispensed item, we don't believe it affects their ability in other spheres of their day-to-day work. Why would it?

The conscience clause is an issue that will always attract attention, especially in today's society where there is heightened awareness of differing human rights. But we're not different to other healthcare professionals' regulatory bodies at the moment – they've all got something like this in their codes of conduct. And the new regulator is mindful of the interest the clause attracts and has indicated that in the future it may be reviewed.

David Reissner: a lawyer's view of the conscience clause

This is a complicated issue and I think pharmacy is going to be damned by the press if it does and damned if it doesn't. We've already seen negative headlines in some sectors of the press about pharmacists providing EHC to teenagers, but if pharmacists don't do it for religious reasons then they will be damned by sectors of the press.

If pharmacists do object, there may be cases where somebody who has been unable to get EHC from a pharmacy falls pregnant and then claims that their pregnancy is due to a breach of duty on the part of the pharmacist. I don't think a claim of that kind would have any merit – at the moment provision of EHC is an enhanced service rather than an essential service so it's not something that pharmacists have to do. But that doesn't stop people trying and there could still be claims against pharmacists.

On the other hand I can see for someone who has a conscientious objection that if they were made to provide EHC then they may be entitled to claim that their human rights were being infringed. Some cases like this have already reached the courts, like the airline employee banned from wearing a cross.

I think the RPSGB or GPhC would be very brave to try to make the supply of contraception a professional requirement for pharmacists.

David Reissner is head of healthcare at Charles Russell LLP, where he is a partner

Do you agree that pharmacists should be allowed to opt out of supplying contraception when they have conscientious objections?

Vote in our online poll at www.chemistanddruggist.co.uk

The Finance Zone

PART 3: Inheritance tax. A little planning goes a long way, says accountant Richard Baker

Ask most people about inheritance tax and they will tell you it's a tax paid by the very wealthy when they die. A succinct summary, but the accuracy of it can be challenged in a number of ways.

Inheritance tax is payable by any UK domiciled individual (broadly those who are legally, permanently resident in the country) who dies with an estate worth in excess of (currently) £325,000. Tax is due at 40 per cent on the excess over this amount.

If the estate is left to a surviving spouse or civil partner, then no tax will be payable as this is covered by a specific exemption. When the surviving spouse or civil partner dies, tax will then be payable on the residue of their combined estates in excess of £650,000.

Even with a stagnant housing market, a combined estate of £650,000 is far from rare, and if you also own your own pharmacy it is easy to see that it is not only the very wealthy who could be paying inheritance tax.

Fortunately, there is a further inheritance tax relief available when a business such as a pharmacy is an asset in the estate. Business property relief (BPR) can be due at either 50 or 100 per cent, depending on the business assets involved.

Do the very wealthy actually pay inheritance tax? Of course they do, but the tax raised is very often much less than might be expected because it can be mitigated by careful planning.

The use of trusts for inheritance tax planning has a long history, but you do not need to go to such complex lengths to minimise your potential inheritance tax liability.

Richard Baker: inheritance tax is no longer a problem for the very wealthy

Key points

- 40 per cent tax payable on any estate in excess of £325,000 left by a UK domiciled individual.
- Business property relief of either 50 or 100 per cent may be due.
- Careful but simple planning can minimise your liability.

Simple steps such as maintaining an up to date will, reviewing your estate to make sure that you do qualify for those important exemptions such as BPR, and making use of the many smaller exemptions that are available, will reduce your exposure to inheritance tax.

A little time and effort spent on inheritance tax planning will often therefore serve to frustrate the Treasury's ambitions, while enriching your children's and your grandchildren's expectations

Richard Baker is a partner at accountancy firm Horwath Clark Whitehill

Horwath Clark Whitehill

NEXT MONTH

The importance of business planning for all sizes of pharmacy

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C+D AWARDS 2010

Three-minute message for Gaviscon

Reckitt Benckiser is now claiming that its Gaviscon liquid heartburn products soothe in three minutes. The company says it is making the claim following extensive research.

To educate consumers about the new three-minute message and encourage trial of Gaviscon liquid sachets, a series of web activities will be rolled out in June as part of a marketing campaign that includes advertising and PR activity.

To kick-start the campaign, Reckitt Benckiser is releasing new research conducted for Gaviscon to find out which everyday tasks men and women could complete in just three minutes.

The research concluded that men perform better at tasks relating to navigation and spatial awareness and women excel in tasks involving hand-eye co-ordination and verbal reasoning.

Stefan Gaa, Gaviscon marketing director, comments: "We commissioned the research as we were very aware of the importance of time when developing the Gaviscon range."

Reckitt Benckiser
Tel: 01482 326151

Buscopan P treatment launch for abdominal cramps

Boehringer Ingelheim is launching a P licensed treatment for the relief of abdominal cramps.

Buscopan Cramps contains hyoscine butylbromide 10mg, which has an antispasmodic effect.

The product is indicated for the relief of spasm of the genito-urinary tract or gastro-intestinal tract and for the symptomatic relief of irritable bowel syndrome.

"Unlike painkillers which mask the pain, Buscopan Cramps works directly on the spasms in the digestive tract to ease the pain and discomfort of abdominal cramps," says Boehringer Ingelheim.

Adults and children (12 years and over) can take two tablets up to four times a day.

The launch will be supported by a £500,000 marketing campaign that includes print advertising from June. Customer information leaflets are available for pharmacies.

Price and Pip code: £4.39/20, 353-1738
Dendron
Tel: 01923 205704
www.stomach-cramps.co.uk

Market focus

- The £4.9 million IBS market has grown by 3.5 per cent in volume over the last year (IRI, February 20, 2010).
- Forty per cent of people in the UK suffer from abdominal cramps, but more than a quarter never treat their symptoms (TNS survey, June 2009).
- Forty six per cent of sufferers of abdominal cramps and spasms would prefer the management of their condition to be pharmcy-led (TNS survey, June 2009).

GSK's new Piri team will align allergy brands

GlaxoSmithKline Consumer Healthcare is to align its Piriton and Piriteze brands more closely under a single range in time for the hayfever season.

The introduction of the new Piri Team will enable the company to support the entire range while capitalising on the Piriton brand heritage.

GSK says the simplified proposition will assist pharmacy staff in the task of recommending an appropriate product and ease customer recognition of the individual products.

The range will be supported by a new £2.4 million TV advertising campaign from May to help increase awareness and drive sales. PoS materials and category management initiatives are also available.

A new 'What a Relief' module in GSK's PharmAssist programme covers all aspects of allergy to help pharmacy staff navigate the range and advise customers.

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

Mineral make-up from Ahava

Ahava UK is extending its Dead Sea mineral skincare range with make-up developed to be suitable for sensitive skin.

Mineral Makeupcare comprises four foundations formulated to care for the skin with Dead Sea algae and minerals. The range includes Rich Foundation for mature or dry skin, Light Foundation for young or oily skin, Compact Powder and Loose Powder. All the products come in four shades to suit different skin tones: Dune, Sand, Clay and Terra.

The range is formulated to smooth over fine lines and provide a natural, even look with long-lasting coverage and natural UVA/UVB protection, says Ahava.

The products contain no artificial dyes, parabens or fragrances and are not tested on animals.

A full range of support materials is available including a retail PoS unit, posters and leaflets.

Prices: from Compact Powder £18.75/9gm to Rich Foundation £22.00/30ml
Ahava UK
Tel: 01452 864574

Mentholatum helps keep runners on track

Runners in the Virgin London Marathon visiting the Marathon Expo to register have a special incentive to visit the Mentholatum stand at London's ExCel exhibition centre from April 21-24.

Mentholatum is offering visitors the chance to win a top of the range running machine as well as picking up some free samples.

Visitors will also be able to buy a promotional sports pack containing a selection of Metholatum topical products and other goodies including a water bottle.

Laser Healthcare
Tel: 01202 780558

Check out what's on TV this week
www.chemistanddruggist.co.uk/prodnews

Calculating the true cost of service

Last Thursday the post arrived even later than usual, and so while drinking the pharmacist's traditionally lukewarm coffee I was looking at the newspaper. "Chancellor made you better or worse off?" proclaimed the headlines. "See our Budget Report for details!" I turned to look at the PPD statement and my wholesaler bills, and reckoned I already knew the answer...

Also in the post was yet another questionnaire. We get no end of surveys from suppliers, or from patient groups raising awareness of Mute Tourette's Syndrome or suchlike. Just recently it's been endless questionnaires from final-year pharmacy students who think the easy way to research is asking stupid questions such as "do you think declassification of Product X from POM to P was: a) helpful and effective, or b) not helpful at all", thus denying a balanced and considered answer. However, today's questionnaire was the Cost of Service Inquiry, with a letter explaining how current funding is based on a 2003 survey, and that PSNC and DH had agreed it was necessary for a new inquiry – presumably because they disagreed about current costs.

Now, even casual readers of my column may have gathered that Xrayser Pharmacy is fairly typical in that we are over-worked, underpaid, undervalued, stressed, and commercially insecure. It's not helped by the papers being full of post-budget doom and gloom, and even C+D struggled to find a 'good news' story last week. It's all more work and financial woe, and only that morning I had let forth a particularly extended rant about an obscure CD we had ordered, only to have the patient ungratefully pass away before we could dispense it, and now we would have to pointlessly count it every week for the next three years before it went out of date and that was another £75 wasted. So this is one survey I'm pretty excited about completing. Especially the bit about costs, and the bit that asks me to apportion the time we spend in 'Clinical Governance' activities – I haven't decided whether to put down 80 or 90 per cent.

But then a customer came over and said what a lovely chemist shop we were, and how she'd heard us talking most helpfully to a patient, and that made me feel better, and a bit later the relative of a recently deceased patient came to return the unused CDs for disposal. As he thanked me for our care for his father I felt guilty, thinking how small £75 was compared to our overall costs of service I'd be reporting, and I knew I didn't always get the balance right. So If I'm part of setting the funding for pharmacy for the next 10 years, which is a pretty big responsibility, I just hope PSNC and DH do a better job of getting the balance right. Hmm.

> THIS IS ONE SURVEY I'M PRETTY EXCITED ABOUT COMPLETING. ESPECIALLY THE BIT ABOUT COSTS

Getting our health priorities right

He remained resolutely unimpressed when I tried to explain that, due to a manufacturing problem, the Panoxyl Wash his GP had prescribed was currently unavailable, but it should arrive later in the week. Not good enough, he needed it now; his skin specialist had insisted he uses it with the other three prescribed medicines. He wanted his prescription back, so I took back the items already dispensed, and explained he would not get the Panoxyl Wash elsewhere.

He returned the next day, untroubled and unabashed, and asked if the Panoxyl Wash had arrived. I explained it should arrive in two days, so he agreed to wait and handed over the prescription to have the other items re-dispensed. About an hour later his father arrived at the pharmacy, halting momentarily to stub out his cigarette. I was in conversation with a patient yet he interrupted, making a very loud protest that the Wash was short.

Dad forcefully explained that his son needed this medicine as an integral part of his treatment. He was at a loss to understand how a hospital-based specialist was prescribing something unavailable and would potentially lead to a treatment failure. I apologised, explaining in layman's terms how manufacturers occasionally mess up the manufacturing process and fail to get a batch released, resulting in a temporary stock shortage.

Like his son he remained unimpressed even when I suggested I contact the GP for an alternative; he felt his GP had been unable to properly treat his son's acne in the first place, thus the need for referral to secondary care.

This incident embodies, for me, the core challenge for public health generally and social inequalities specifically. The son's acne is not, by any stretch of the imagination, a serious health problem. Untreated it is of no health consequence. However, the family have prioritised this as a key health need and are demanding a service to address it.

Dad, a cigarette smoker, is grossly overweight, has type 2 diabetes and last year suffered a heart attack – he is only 50. Mum is also overweight, which explains why their beloved son is overweight; a factor that is possibly worsening his acne. Will the focus on his acne have any impact on the number of years he lives or on his quality of health during these years?

Cigarette smoking, poor diet and lack of exercise coupled with relative poverty are the only factors in the creation of social inequalities. These are the core issues the health service must address if it wishes to close the gap between the health of the well off and the less well off.

Tragically, in respect of public health and individual personal health, the less well off fail to appreciate what is important and what is unimportant and in doing so seem unable to help themselves. How does the health service, and those who work in it, say to these families that it's not because you have acne that you have a shorter and less healthy life, it's because you are fat, sedentary and smoke. They would be much better for it but our politically correct culture denies us this option.

Terry Maguire is a community pharmacist in Northern Ireland

> IT'S NOT BECAUSE YOU HAVE ACNE THAT YOU HAVE A SHORTER AND LESS HEALTHY LIFE, IT'S BECAUSE YOU ARE FAT, SEDENTARY AND SMOKE

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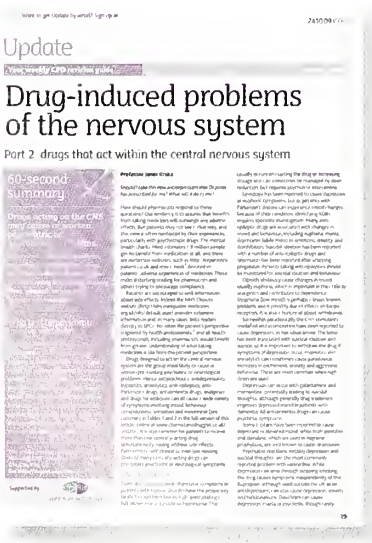
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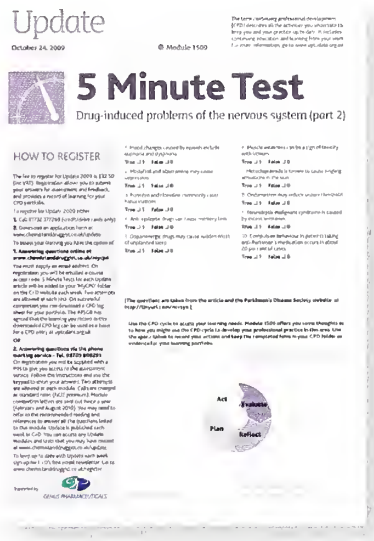
Drug-induced problems of the nervous system

Part 2 drugs that act within the central nervous system

60-second summary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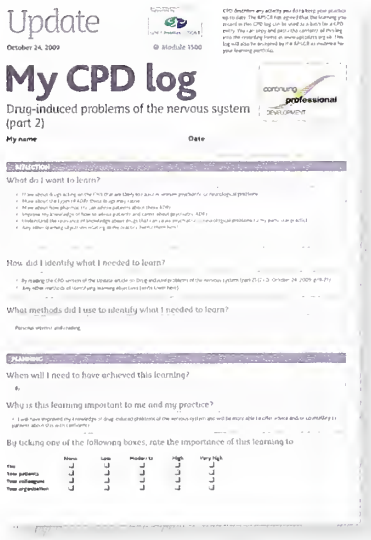
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Drug-induced problems of the nervous system (part 2)

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Update

Your weekly CPD revision guide

Pregnancy: key changes in the second trimester

The second of three articles describing the baby's development and physiological changes in the mother

60-second summary

This article, which can support your CPD, will help you when answering questions from prospective parents.

What are the key changes in the baby?

By 26 weeks the foetus moves, sucks its thumb and hiccups. It digests amniotic fluid and the kidneys excrete urine. It can respond to sounds such as its mother's voice and the retina is sensitive to light. Fat is laid down in the skin, which is covered in fine hair and a waxy layer protecting it from the amniotic fluid.

What about the mother?

Cardiac output increases while peripheral resistance decreases to prevent blood pressure rising, but increased abdominal pressure can lead to varicose veins and haemorrhoids. Indigestion and constipation may be problematic, and there is a risk of gestational diabetes.

This article (Module 1520) can help in the following CPD competencies: G1a, G1c, G1d, C1a, C1f. See http://tinyurl.com/68ox7b

Katharine Gascoigne MRPharmS

The second trimester of pregnancy is classed as the weeks 13 through to 26. During this time the foetus grows steadily and increases weight 30-fold. The mother usually feels fitter as the nausea and tiredness typical of the first trimester disappear.

Development of the baby

At the beginning of the second trimester the head of the foetus is still relatively large, but from week 13 the length of the body and limbs increases rapidly; by week 20 the head makes up less than one third of the body's total length and the legs are longer than the arms. At 22 weeks the proportions are as those of a newborn, although the foetus is very thin because fat has yet to be laid down.

The rate of growth gradually slows and the baby's development continues with the lungs, digestive tract, nervous and immune system starting to mature. By the end of the second trimester the baby is able to make deliberate movements, can suck its thumb and is prone to hiccups. It swallows and digests large amounts of amniotic fluid, and the waste passes across the placenta via the umbilical cord into the mother's blood. The foetal kidneys excrete urine back into the pool of amniotic fluid, which is now around 500ml in volume and is entirely replaced or recirculated every three hours.

The foetus practises breathing movements from now until birth. The lungs are full of amniotic fluid, which aids the development of alveoli, with the buoyant environment enabling their growth and expansion.

Calcium continues to be deposited onto the cartilage skeleton and all the joints are able to move. Myelin begins to cover the nerves. The circulatory system and urinary tract are in place by 16 weeks. The foetus now looks more like a baby. The ears stand out from the side of the head and the bones within the ears harden so that sounds can be heard for the first time. By the end of this trimester the nervous system will have developed sufficiently for the foetus to recognise and respond to certain sounds such as its mother's voice.

The eyes are still spaced wide apart but look straight ahead and the retina is sensitive to light, although the eyelids remain sealed shut until 26 weeks. The tongue is covered in taste buds and teeth buds are already present within the gums.

The skin becomes less translucent as fat is laid down. The epidermal layer has the beginnings of finger- and toe-prints. At five months the foetus is covered in a fine layer of lanugo hair, which is shed between seven and eight months. It is also covered in a thick layer of vernix caseosa, a waxy layer that protects the skin while it is immersed in amniotic fluid. This has usually all gone by 40 weeks, but premature babies are often still coated in this white substance.

The sexual organs are well developed and clearly visible at a 20-week ultrasound scan. Half way through pregnancy a female foetus's ovaries contain six million eggs, with this figure already reduced to around one million at birth.

In the UK a foetus is legally defined as viable by 24 weeks. A baby born from this stage onwards has a chance of surviving, although the risk of physical or mental disability remains high up to 30 weeks.

Changes in the mother

This trimester is generally when a pregnant woman feels her best. The nausea and tiredness she may have experienced have usually passed and the risk of miscarriage is greatly reduced. She begins to look pregnant and between 16 and 20 weeks will experience the first sensation of foetal movement known as quickening.

Cardiac output continues to increase while the peripheral resistance of the blood vessels decreases to prevent blood pressure rising. This, together with increased pressure in the lower abdomen from the growing uterus, can lead to problems such as varicose veins and haemorrhoids. From this stage onwards it is advisable for the mother to avoid standing or sitting in one position for long periods.

If haemorrhoids have been diagnosed by a doctor or midwife a number of OTC preparations may be recommended, although those containing hydrocortisone should not be used in pregnancy. Constipation is often a contributing factor and may be avoided by increasing fibre and fluid intake and by being physically active.

Blood volume increases, resulting in an increased workload for the kidneys, which filter 60

per cent more blood than normal. This overload can sometimes result in small amounts of glucose and protein in the urine. A large amount of blood is stored in the pelvic and leg veins and this may lead to dizziness and headaches on standing. Increased blood supply to the skin and mucous membranes often causes nasal congestion, bleeding gums, nose bleeds, darkening of the genitalia and sweating. Skin can become dry and itchy for which emollients may be beneficial.

High levels of oestrogen stimulate production of melanin, which darkens the areola and any moles, freckles, birth marks or scar tissue the mother may have. A line of pigmentation down the middle of the abdomen called the linea nigra may appear from this stage onwards and some women also develop chloasma, a similar darkening of skin but across the face (often called the mask of pregnancy). These effects fade after childbirth.

Towards the end of the second trimester the uterus grows upwards, forcing the ribcage up and out. This is often accompanied by pain as the ligaments stretch, and breathlessness as the lungs are impacted.

The increasing size of the uterus reduces the stomach's capacity, and digestion is slowed down by progesterone, often causing indigestion. This slow-down can lead to constipation, for which a bulk laxative or lactulose may be suggested, as well as the usual advice to increase intake of fibre and fluids. Senna should not be used as its irritant effect on the gut has the potential to trigger contractions.

Heartburn may become a problem towards the end of this trimester because of the relaxant effect of progesterone on the lower oesophageal sphincter. Advise eating little and often, avoiding foods that trigger symptoms, sleeping with extra pillows to raise the head and not eating too close to bedtime. Most antacids are safe to recommend.

Pregnancy hormones

Hormone	Source and effect
Human chorionic gonadotrophin (HCG)	First produced by the embryo then the placenta, it maintains production of progesterone by the corpus luteum until the placenta takes over.
Oestrogen	Present mainly as oestriol produced by the placenta but also produced by the foetus, it increases blood supply to the mother's vital organs and promotes development of the uterus and breasts. It also softens collagen in connective tissue to loosen up ligaments.
Progesterone	Produced at first by the corpus luteum then later by the placenta, it has a relaxant effect on blood vessels, muscles and ligaments and the digestive and urinary tracts. It also prevents contractions until birth and has a role in preparing the breasts for lactation.
Prolactin	Produced in the anterior lobe of the pituitary gland, it stimulates milk production.
Relaxin	Produced by the ovaries, it softens pelvic ligaments and prepares the cervix for childbirth.
Oxytocin	Produced by the posterior lobe of the pituitary gland, it causes uterine contractions.
Human placental lactogen (HPL)	Produced by the placenta, it diverts glucose from mother to foetus and effects maternal insulin production and uptake to help the transfer of nutrients to the foetus. HPL also has a role in breast development and milk secretion after delivery.
Cortisol and adrenocorticotrophic hormone (ACTH)	Secreted by maternal adrenal glands, with some cortisol produced by the placenta. Increasingly produced during the second and third trimesters, the effects lead to stretch marks and high blood glucose levels. Cortisol helps maturation of lungs.
Androgens	Produced mainly by the foetal adrenal gland and used to manufacture oestrogen. Testosterone is needed for the development of male external genitalia.

Gestational diabetes

In the second half of pregnancy the risk of gestational diabetes (also known as gestational diabetes mellitus or GDM) increases. It is more likely in women over 30, those with a BMI above 30 or who have previously given birth to a large baby, women with a history of GDM or family history of diabetes, or women of south Asian, black Caribbean or Middle Eastern origin. GDM is thought to be caused by pregnancy hormones blocking the effects of insulin and a subsequent inability of the pancreas to counter this effect.

Hyperglycaemia results and GDM may be diagnosed with an oral glucose tolerance test at 16 to 18 weeks and 28 weeks. The high maternal blood glucose levels cause the foetal pancreas to produce more insulin. This can lead to macrosomia (big baby syndrome) or polyhydramnios (excess amniotic fluid). Premature labour or complications during labour and birth often result, so pregnant women with diabetes are given extra antenatal appointments and growth scans. Most women are able to control their diabetes using dietary measures alone and should receive help with this from a dietician. If stable blood glucose levels are not achieved or if the baby appears very large in an ultrasound scan then treatment with insulin or metformin and/or glibenclamide may be required for the rest of the pregnancy. Women who suffer GDM often go on to develop diabetes in later life.

Antenatal care

During this period there are usually few antenatal appointments, but certain conditions mean extra appointments are required. These include multiple pregnancies, a previous pre-term delivery or low/high weight baby, a baby with a congenital abnormality and certain underlying conditions such as hypertension, diabetes and epilepsy.

At around 18 to 20 weeks the foetal anomaly ultrasound scan is offered. This is when the development of each of the baby's organs is checked and measurements of the head, abdomen and femur are taken to establish whether the size of the baby is correct in terms of its due date. The baby's sex may also be revealed.

Among other things, the ultrasonographer checks each vertebra of the spine to rule out defects such as spina bifida, confirms the abdominal wall is sealed and encloses the intestines, and checks that the diaphragm is complete and separates the chest from the abdominal cavity. The amount of amniotic fluid is measured and the position and size of the placenta is checked. If the placenta is low-lying (covering the cervix), another scan at 32 weeks may be required to ensure a safe delivery.

If at this or a previous scan a potential abnormality is highlighted or if the mother has certain risk factors, further ultrasounds or screening tests may be recommended. Tests include amniocentesis or chorionic villus sampling to determine whether a foetus has Down's syndrome, and various serum screening tests that help establish a baby's risk of other chromasomal abnormalities or an open neural tube defect.

The final article in this series scheduled for May 1 will cover the the third trimester of pregnancy, including labour and childbirth.

References are online at www.chemistanddruggist.co.uk/update

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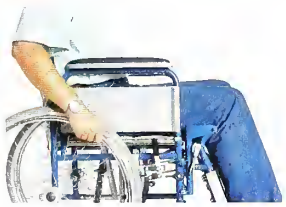

NEXT WEEK
The diagnosis and management of motor neurone disease

Pregnancy: key changes in the second trimester

What is vernix caseosa? Which patients have a higher risk of gestational diabetes? What is the role of progesterone in pregnancy?

This article describes the second trimester of pregnancy including foetal development, maternal changes and common pregnancy problems such as indigestion and constipation. It also discusses gestational diabetes, pregnancy hormones and antenatal care.

Plan

- Revise your knowledge of haemorrhoids from the Clinical Knowledge Summaries (CKS) website at http://tinyurl.com/yjsxmwn. Think about the advice and products you could recommend to pregnant women.
- Read the patient information leaflet about indigestion in pregnancy, available on the CKS website at http://tinyurl.com/ykq5ww9. Which OTC medicines would you recommend? Make sure your counter assistants are aware of your choices.
- Think about the advice you could give on oral hygiene in pregnancy. Customers may find the Netmums website useful at http://tinyurl.com/yh3c88c.
- What advice could you give about varicose veins and skincare during pregnancy?
- Find out more about gestational diabetes from the Patient UK website at http://tinyurl.com/yfrakum.

Act

Are you now confident in your knowledge of the second trimester? Could you advise patients about common problems in pregnancy and about gestational diabetes?

5 minute test

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Get a CPD log sheet for your portfolio when you successfully complete the 5 Minute Test online.

Practical Approach

A case of chronic diarrhoea

Salma Hussain, formerly pre-registration trainee at the Update Pharmacy and now a locum, is working again at Update while pharmacist David Spencer is on holiday. A woman asking for something for diarrhoea has been referred to Salma, who sees her in the consultation area.

The woman explains: "I went out with some friends to a pizza restaurant yesterday and I've had the most terrible diarrhoea and pains in my abdomen since."

Salma establishes that none of the woman's friends appears to have been affected by the meal, and asks whether she has had attacks like this before.

The woman replies: "Actually, yes. I've been getting diarrhoea on and off for about the last 15 years, since I was 17. I sometimes get bouts of constipation too."

"Have you seen your doctor about it?" Salma asks.

"Oh, yes. I went about a year ago and he said he thought I had irritable bowel syndrome. I've tried several over the counter medicines, but they don't help much. Recently, the problem's been getting worse, and it's making me very tired and depressed. Actually I'm worried that I might have cancer."

"Well, of course you'll need to go back to your GP for a proper investigation," Salma says, "but what you've described sounds very much like a condition that runs in my family. And if it is, it's easily controlled and you actually won't need to take any medicines."

Questions

1. Assuming Salma's provisional diagnosis is correct, what might the woman's condition be and how common is it?
2. Apart from chronic diarrhoea and abdominal discomfort, what are the common clinical features in adults?
3 What tests and investigations are used to confirm the condition?
4. What is the treatment?
5. In which section of the BNF can treatments for this condition be found?

Answers

1. Coeliac disease, a genetically-determined sensitivity to gluten, a protein found in wheat, rye and barley, causing chronic inflammation of the small intestine. Prevalence is about one in 100 people in the UK.
2. Anaemia, arthralgia (joint pain), fatigue and general malaise, steatorrhoea (fatty stools), mouth ulcers, angular stomatitis, dermatitis herpetiformis (an intensely itchy blistery rash that characteristically affects extensor surfaces, particularly the scalp, buttocks, elbows and knees).
3. Blood tests: IgA anti-tissue transglutaminase antibodies (tTGAs) is the preferred investigation; an older test, for endomysial antibodies (EMAs), is used if the tTGA test is not available or equivocal. Both are highly specific and sensitive provided the patient is still consuming gluten-containing foods. Diagnosis can be confirmed by intestinal biopsy.
4. A diet containing no wheat, barley, rye, or any food containing them (eg bread, cake, pies), although moderate quantities of oats can be tolerated by most coeliacs. Rice, maize, soya, potatoes, sugar, jam, syrup and treacle are all allowed. Many gluten-free biscuits, flour, bread, pasta and other products are available.
5. There is no treatment as such, but Appendix 7, Section 6 lists gluten- and wheat-free products that can be prescribed on the NHS.

This article can help with these CPD competencies: G1a, G1c, G1d, G2a, C1a, C1f.
See http://tinyurl.com/68ox7b

To see the full archive of Practical Approach articles go to www.chemistanddruggist.co.uk/practicalapproach

Be prepared to answer customer concerns about codeine, and self-management of pain generally, says **Ailsa Colquhoun**, as new addiction warnings start to appear on OTC packs

Managing codeine concerns

As new OTC codeine packs start to filter their way through to shelves, pharmacists and pharmacy staff are likely to find themselves faced with patients who need reassurance about OTC codeine- and dihydrocodeine-containing analgesics and, by extension, perhaps about OTC analgesics in general.

In September, UK medicines regulator the MHRA introduced a package of measures intended to minimise the risk of codeine/dihydrocodeine addiction (C+D, September 12, p6). These included prominent pack warnings (see box, MHRA measures, opposite), and the new livery featuring these are now likely to be making their way onto pharmacy shelves.

Many patients will have read for themselves, or will have been told about, codeine dependency. And dependency and abuse stories in the consumer media could prompt scrutiny of the way pharmacies sell codeine/dihydrocodeine-based products.

A new leaflet on pain management from the British Pain Society, released last week, directs patients to talk to their pharmacist as the expert on OTC painkillers, as does the new-look patient information that the industry has placed in and on the new codeine/dihydrocodeine OTC packs. Clearly, pharmacists and pharmacy staff will need to be ready for the questions that are likely to come.

Abuse and misuse

Over the years there have been various attempts to assess the extent of OTC drug dependency in the UK, but evidence of a problem, or of its increasing severity, still remain anecdotal.[1] Due to the secretive nature of addiction, it is likely that absolute numbers of OTC drug misusers or abusers will never be known as it requires people to recognise that they have a problem, seek help from a health professional and have a record made. Furthermore, people may be reluctant to classify themselves as drug users because of the stigma attached.

Healthcare professionals, regulators and industry stakeholders have long recognised the potential for codeine/dihydrocodeine to cause dependency, and have made efforts in the past to reduce the likelihood of dependency occurring.[2]

But independent research has shown that the vast majority of people in the UK use medicines wisely[3] and that they respect over the counter products in the same way as they do prescription medicines.[4]

Specifically referring to the safety record of OTC codeine/dihydrocodeine, MHRA director of vigilance and risk management of medicines Dr June Raine has said: "Taken in the correct manner and for the right purposes, codeine and dihydrocodeine are very effective and acceptably safe medicines."[5]

Pharmacists at the forefront of pain management

As the most accessible provider of care for people with painful conditions, pharmacists have a key role to play advising patients. As well as helping people to see their way through the headlines surrounding codeine use, and helping them to use all OTC analgesics in accordance with the new rules (see box right, MHRA measures, for revised indications), pharmacists and pharmacy staff will find their pain management counselling roles tested by three main groups of patients in particular:

- People who take codeine every day and now realise they are addicted. These people may need advice on general pain relief.
- People who need referral to a doctor for conditions such as persistent pain or chronic daily headache.
- People who take up to the maximum amount every day for persistent pain relief on medical advice and need reassurance.

To help pharmacies manage sales of codeine products in these situations, the Proprietary Association of Great Britain (PAGB) has published a number of codeine sales scenarios offering practical guidance on patient counselling (see www.chemistanddruggist.co.uk/clinical).

On pain relief more generally, there is also the new British Pain Society leaflet – Managing your pain effectively using Over the Counter (OTC)

medicines – which carries sections for consumers on recognising addiction, recognising medication overuse headache, and making the best use of all OTC analgesics. This is available to download from www.pagb.co.uk and www.britishpainsociety.org.

In addition, the RPSGB has a Law and Ethics Bulletin that expands on updated advice on supply of OTC medicines containing codeine or dihydrocodeine.[6]

Why rise to the challenge?

Professional guidance from the RPSGB already supports pharmacies in the supply of medicines subject to misuse or abuse. Apart from the way the media will scrutinise this and the way that pharmacies apply the new sales protocol for OTC analgesics, there are other good reasons why pharmacists should raise their game when it comes to the management of the new OTC codeine/dihydrocodeine sales rules.

Speaking at a November conference entitled Time to change the culture of dependency on the NHS, GPC negotiator Dr Beth McCarron-Nash said that many GPs still need to be convinced of pharmacists' ability to manage self-care.

She said: "They need to have confidence in pharmacists – who in turn need to be empowered – and be confident that their patients do know when self-care is appropriate, and that there are systems to provide a safety net."

Recently, pharmacies proved themselves capable of managing the sale of another group of OTC products subject to misuse – pseudoephedrine and ephedrine – directly preventing a subsequent P to POM reclassification, and it is the hope of doctors, patients and industry that they will do so again, this time with codeine/dihydrocodeine.

It is the view of the Bandolier journal editor Andrew Moore that codeine has a very valuable place on the OTC analgesic fixture. Professor Moore says: "The bottom line is that while common drugs like paracetamol and ibuprofen are good analgesics, combination products are better than components alone, and that is especially true when codeine is added."

Furthermore, last year, at the time of the All-Party Parliamentary Group on Drugs Misuse (APPGDM) report into OTC drug misuse,[1] MPs and patient representatives also both endorsed the appropriateness of OTC codeine availability. APPGDM chairman Dr Brian Iddon and drugs information agency Over-Count director David Grieve agree that doctors could not cope with the increased workload and that patient access to effective products would suffer if codeine became a POM. Mark Edwards, joint administrator of the codeine self-help group CodeineFree adds: "Speaking to your general practitioner is one thing that people can find very hard to do as many feel like it is a guilty secret. Also, the response from the GP can be like a lottery."[7]

For these reasons, the MHRA is maintaining the position that: "The removal of codeine from pharmacy availability would be a huge disadvantage to the millions of users who successfully take the medication appropriately and without adverse event."

Boosting self-care awareness

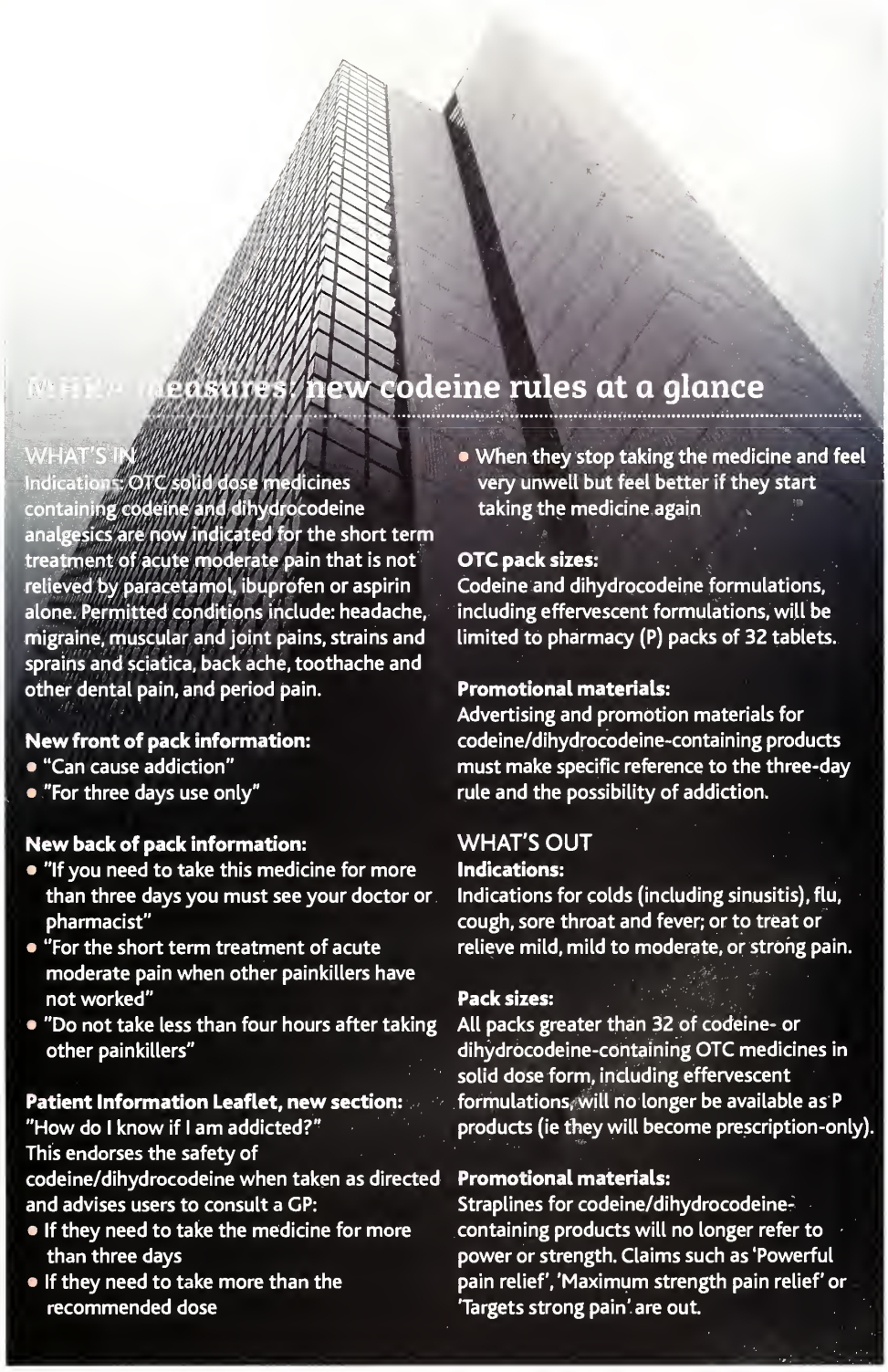
By successfully implementing the new sales approach to OTC analgesia, pharmacists will also demonstrate that they can manage a wide range of minor ailments over the counter, helping people to take responsibility for their own self-care, reducing dependence on the NHS and, ultimately, the number of inappropriate GP consultations for minor ailments.

Industry's new OTC sales rules for codeine/dihydrocodeine products clearly challenge pharmacies to raise the standard of care they offer patients with painful conditions, but they also present an opportunity for pharmacies to shine as the gatekeeper of appropriate minor ailment care. Whatever the true extent of the problem of OTC drug dependency, the most important issue for stakeholders is that preventative moves to reduce the risk of OTC codeine misuse should be taken immediately and effectively. By investing in new packaging and patient support for codeine/ dihydrocodeine products, industry is doing its bit. As PAGB chief executive Sheila Kelly says: "It should be the fundamental desire of us all that codeine sales are not driven by dependency."

This article was written in consultation with the British Pain Society and the Proprietary Association of Great Britain (PAGB)

References are available online
www.chemistanddruggist.co.uk/clinical

For practical [illegible] illustrating how pharmacists can help customers safely manage codeine use and pain, visit www.chemistanddruggist.co.uk/clinical



MHRA measures: new codeine rules at a glance

WHAT'S IN

Indications: OTC solid dose medicines containing codeine and dihydrocodeine analgesics are now indicated for the short term treatment of acute moderate pain that is not relieved by paracetamol, ibuprofen or aspirin alone. Permitted conditions include: headache, migraine, muscular and joint pains, strains and sprains and sciatica, back ache, toothache and other dental pain, and period pain.

New front of pack information:
- "Can cause addiction"
- "For three days use only"

New back of pack information:
- "If you need to take this medicine for more than three days you must see your doctor or pharmacist"
- "For the short term treatment of acute moderate pain when other painkillers have not worked"
- "Do not take less than four hours after taking other painkillers"

Patient Information Leaflet, new section:
"How do I know if I am addicted?"
This endorses the safety of codeine/dihydrocodeine when taken as directed and advises users to consult a GP:
- If they need to take the medicine for more than three days
- If they need to take more than the recommended dose
- When they stop taking the medicine and feel very unwell but feel better if they start taking the medicine again

OTC pack sizes:
Codeine and dihydrocodeine formulations, including effervescent formulations, will be limited to pharmacy (P) packs of 32 tablets.

Promotional materials:
Advertising and promotion materials for codeine/dihydrocodeine-containing products must make specific reference to the three-day rule and the possibility of addiction.

WHAT'S OUT

Indications:
Indications for colds (including sinusitis), flu, cough, sore throat and fever; or to treat or relieve mild, mild to moderate, or strong pain.

Pack sizes:
All packs greater than 32 of codeine- or dihydrocodeine-containing OTC medicines in solid dose form, including effervescent formulations, will no longer be available as P products (ie they will become prescription-only).

Promotional materials:
Straplines for codeine/dihydrocodeine-containing products will no longer refer to power or strength. Claims such as 'Powerful pain relief', 'Maximum strength pain relief' or 'Targets strong pain' are out.

CATEGORY FOCUS

Lower GI

Boost your share of the lower GI market by linking sales to growing service opportunities, suggests **Chris Chapman**

You could think the lower gastrointestinal (GI) market is going down the pan – at least for pharmacy. The sector's share in the anti-diarrhoea subcategory saw a sharp fall in 2009, according to data analysts IRI, with a shrinking market and gains in market share by supermarkets seeing a decrease worth almost £2 million in pharmacy sales.

One of the key factors may be the switch of loperamide, the best-selling drug in the category (in the form of the Imodium brand), from P medicine to GSL in late 2008, causing a knock-on effect on pharmacy's market share. But pharmacists can fight back by providing expert advice around the condition, suggests Julie Lamble, nutritional biochemist for Lifeplan Products.

Ms Lamble says one particular area where pharmacists can make a difference is travel health. As diarrhoea is more common in travellers due to changes in dietary intake, she suggests there is an opportunity for linking probiotic sales when customers are preparing to travel. "Evidence supports taking a probiotic every day for two weeks before a holiday can reduce the risk of Delhi belly on holiday by up to 50 per cent," she says.

Constipation is a large part of the lower GI category. According to the Self Care Campaign, it is the fifth most common minor ailment patients present to GPs in the UK, resulting in 4.3 million consultations a year. However, while a wide range of interventions are available OTC, including faecal softeners and bulk-forming laxatives, Ms Lamble says the best advice is to increase water consumption and increase fibre intake to 15g a day.

Another key area for pharmacists is the irritable bowel syndrome (IBS) subcategory, with more than four million UK sufferers, according to Nice, and over 100,000 new patients each year. While the size of the UK IBS market has remained stable at around £5m per year, IBS presents a strong opportunity for linking sales with other medicines.

Antispasmodics such as hyoscine (as the Buscopan brand), peppermint oil (Colpermin) and mebeverine (Colofac) lead the market, but IBS can present in other ways for more sales opportunities, says Duns pharmacist George Romanes. "If patients are going through spasms and nausea, you've got OTC options including domperidone," he says.

One potential area of expansion within the IBS subcategory is in gluten-free foods for patients with coeliac disease. However, with few PCTs offering an NHS gluten-free service, it's uncertain whether many pharmacists are best placed to take advantage. Bipin Patel, of Clockwork Pharmacy in Islington, says competition with supermarkets and the use of pre-payment certificates means he exclusively sees the items on prescription. "Very few people buy the items, as they can get them on prescription. I've never sold anything OTC," he says.

Another key reason for the lack of role for pharmacies is a shortage of floor space to offer gluten-free products, as the bulky nature of the products takes up valuable shelf space. But this can be turned into an advantage, says Numark service development manager Christina Knott.

"As many of the items are bulky, the pharmacy can provide a delivery service and protect that customer's business from the competition," she suggests. Pharmacies can further cement customer loyalty by signposting to support groups, displaying leaflets and liaising with local GP practices to ensure the right items are prescribed, she adds.

And the growth potential of the market may be boosted through new services. PSNC is currently looking to develop the provision of gluten-free products as a national service specification, says head of NHS services Alastair Buxton. However, any service specification is viewed as a long-term goal, he warns, meaning pharmacists considering developing the service may be best served by making local arrangements.

Brand Watch: Juvela

Gluten-free foods provider Juvela is launching a campaign to raise awareness of coeliac disease through community pharmacy this spring.

The brand is supporting Coeliac Awareness Week (May 10-16) with an awareness poster (below right) specially designed to be displayed in community pharmacies. "Often pharmacists are in the front line of people with IBS-type symptoms who may in fact be suffering from coeliac disease," says a Juvela spokesperson on why they are focusing on the sector. "[Pharmacists] do pick these things up and direct people back to their doctor for testing."

To obtain a free poster, email info@juvela.co.uk or call 0800 783 1992, quoting 'pharmacy'.

Top tips for boosting your low

1. "For those who need help with constipation, a dietary top-up with good quality fibre supplement is highly recommended. Ideally, look for a brand registered with the Vegan Society, one that's free from gluten and contains no added starch, sugar, or salt and, more importantly, one that provides both soluble and insoluble fibre in each tablet."
Julie Lamble, nutritional biochemist, Lifeplan Products

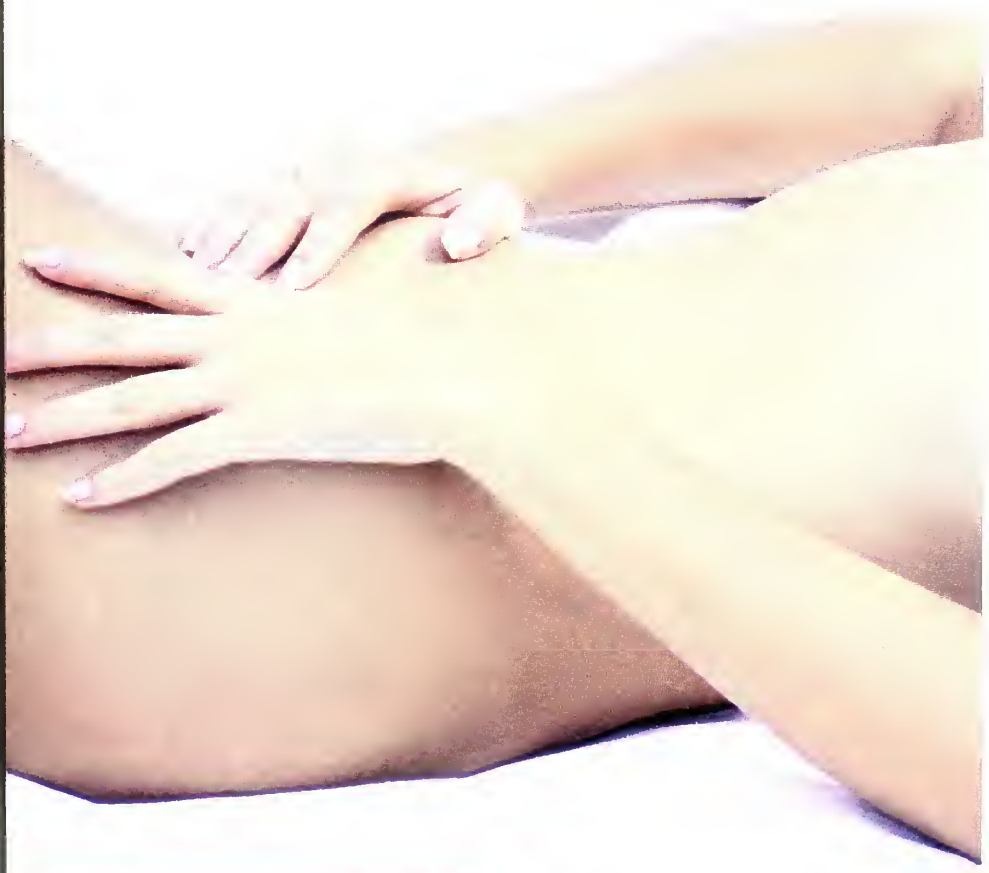
2. "Dehydration is a factor in diarrhoea. I always try and recommend something to rehydrate the patient, either in addition to, or rather than, loperamide."
Bipin Patel, Clockwork Pharmacy

£45m
Total value of the anti-diarrhoea subcategory

59%
Pharmacy share of the anti-diarrhoea subcategory

72%
Pharmacy share of the IBS subcategory

Source: IRI value sales, 52 weeks to December 26, 2009



Market Insight: lower GI

The top line trend in the overall GI market at the moment is that sales are broadly down across the subcategories, as financial issues are getting more embedded and markets are slowing down.

A lower GI subcategory – irritable bowel syndrome (IBS) – is the only GI subcategory in growth. This increase may be linked to stress – IRI has hypothesised that, as financial problems in the country have got worse, there has been an increase in stress-related categories. IBS is one of those – though it's not showing a significant growth trend at just 1 per cent.

And IBS is still a very small subcategory. This may be because people who have IBS are still getting their medicines through prescription, though the low level growth may point towards increasing self-medication.

Market changes 2008-09 Irritable bowel syndrome (IBS)

Total market
£4,931,780 ▲ +1%

Pharmacy market value
£3,565,586 ▼ -0.1%

Grocery market value
£1,365,880 ▲ +3.9%

Best selling IBS brands

1. Buscopan
2. Colpermin
3. Colofac
4. Mintec
5. Spasmonal

(total market)

Market changes 2008-09 Anti-diarrhoea

Total market
£45,247,420 ▼ -1.1%

Pharmacy
£26,502,564 ▼ -6.4%

Grocery
£14,977,568 ▲ +7.8%

Best-selling anti-diarrhoea brands

1. Imodium
2. Dioralyte
3. Own label
4. Diocalm
5. J Collis Browne's

(total market)

Source: IRI value sales 52 weeks to December 26, 2009. Data and analysis provided for C+D by IRI

IRI Breakthrough Insights. Breakthrough Results.

offering

3. "Coeliac UK has local branches scattered around the country. LPCs could think about getting help from patient power [to apply for a gluten-free enhanced service]."
Alastair Buxton, head of NHS services, PSNC

4. "Stocking gluten-free products can be used as an enabler to discuss lifestyle with the patient. You could link this to other services, such as weight management or food intolerance testing. And as many of the items are bulky, the pharmacy can provide a delivery service to protect that customer's business."
Christina Knott, service development manager, Numark

Case study

ROMANES PHARMACY, DUNS
GEORGE ROMANES

Mr Romanes has seen an increase in sales since his pharmacies began a minor ailments scheme (MAS), part of the Scottish pharmacy contract. He says the mix of products available means pharmacists can treat more patients with diarrhoea, constipation and IBS. "I think there's been an increase, as people realise you can prescribe more than you did... an MAS service is ideal." While Scottish pharmacies shouldn't use MAS as a selling point in advertisements, delivering a first-class service can see a boost in OTC sales as patients turn to your pharmacy for advice, Mr Romanes adds. "The best advocate is the patient."

Top 10 websites for pharmacists

Unsure of where to look for advice on the internet? **Chris Chapman** lists the essential sites you should save to your favourites list

Chemist+Druggist

www.chemistanddruggist.co.uk

Arguably a biased first choice, but C+D's website is packed with useful information for pharmacists, from the latest breaking news to clinical and CPD resources, and MUR guides. The site is chock-full of exclusive online content, including news, views, conference coverage and video blogs. You can also sign up to news and CPD emails, or follow us on Twitter.

Pharmaceutical Services Negotiating Committee (PSNC)

www.psnc.org.uk

Find information on the contract, IT, funding and the Drug Tariff, services in England and Wales, details of manufacturer supply deals and links to guides on pharmacy practice.

NHS Choices

www.nhs.uk

Primarily for the public, NHS Choices features general information on hundreds of conditions and the inside track on health stories in the news. The site also provides access to the NHS direct website (www.nhsdirect.nhs.uk).

National Electronic Library for Medicines

www.nelm.nhs.uk/en

The largest medicines information site in the NHS, the library houses everything from product information to evidence-based reviews of drugs and drug therapies. The library gathers its collection from a variety of sources, including UK Medicines Information (www.ukmi.nhs.uk), the National Prescribing Centre (www.npc.co.uk) and Nice (www.nice.org.uk).

Clinical Knowledge Summaries

www.cks.nhs.uk

Formerly Prodigy, this is a clinical database for primary healthcare professionals. Around 250 clinical conditions are covered, with guides on diagnosis, management and prescribing advice. Printable information for patients is here, too.

Electronic Medicines Compendium

emc.medicines.org.uk

The website houses almost 7,000 patient information leaflets, which are available to download, and summaries of product characteristics. The site is updated to keep track of changes.

The Medicines and Healthcare products Regulatory Agency

www.mhra.gov.uk

This contains a one-stop section for pharmacists, including a list of hot topics and safety updates as well as drug alerts and product recalls. Pharmacists can also report counterfeit medicines or side effects through the yellow card scheme.

The Department of Health

www.dh.gov.uk

The DH website is vast, featuring the latest goings on from the government on matters of health policy. All DH documents are available to view on the site, along with letters from senior staff. For health policy, this should be your first port of call.

RPSGB/General Pharmaceutical Council

www.rpsgb.org
www.pharmacyregulation.org

The RPSGB website contains the latest on regulation, ethics and pharmacy practice. The site also holds the current registers. The website will be used by the professional leadership body, the Royal Pharmaceutical Society, when it forms after the General Pharmaceutical Council (GPhC) is created. The GPhC's website contains everything you need to know about the new body, including a FAQ section on standards and registration.

Chemist+Druggist Jobs

www.chemistanddruggistjobs.co.uk

If you're looking for a job or just want tips for how to excel in your career, C+D's jobs site is an essential port of call. Hundreds of pharmacy jobs are advertised on the site, from positions with independent pharmacies to careers with the largest multiples. C+D's careers articles are also available to help you get ahead.

pharmacists Want to chew the fat with other pharmacists in the UK? These two sites are a good place to start. discussion group for locum pharmacists, LocumVoice is a hotbed of debate covering all aspects of pharmacy. forum.php Another forum for discussion between pharmacists, Pharmacy Forum UK contains the latest news and chat, and support.

g engine such as Google deliver a good list of results, but Searchmedica, which has been developed by C+D's parent engine allows you to tailor your search to recommended medical sites, both in the UK and internationally, to the NHS. You're even able to refine your search to information for pharmacists – **www.searchmedica.co.uk**

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Springboard is a pre-registration programme offered by Medway School of Pharmacy in partnership with C+D. Springboard equips pre-registration students with the skills and confidence to ensure a smooth transition from pharmacy graduate to practicing pharmacist.

The Springboard pre-registration training programme consists of eight study days facilitated and delivered by staff from C+D and Medway School of Pharmacy covering a wide variety of topics, enabling students to meet the appropriate competencies in the RPSGB's student handbook.

Springboard is unique in that by the end of the course the students will have also completed an accredited medicines use review training programme, the C+D Counterpart pharmacy assistant course, the Practice Certificate in Pharmacy Management course, as well as receiving a subscription to an online practice exam question website.

Springboard also includes a training day for the pre-registration tutor.

The cost of Springboard is from £1,200 (+ VAT) per student.

For more information phone 0207 921 8413 or email kinna.mcconochie@ubm.com

Your questions answered

Why would I want to become a PhwSI?

Lots of reasons, says Bradford-based locum and PhwSI Marta Hildebrandt:

The job satisfaction is immense and continual.

The clearly defined role gains recognition by patients and greater status among other healthcare professionals and peers.

Widening job prospects.

The opportunity for training and development of clinical skills to an advanced level, to become a practitioner of a specialised service.

The opportunity to provide a wider range of clinically effective services, directly to patients and without direct supervision, in a primary care setting; to be part of the drive for improving access to services, thus tackling long standing health inequalities and providing convenient individualised care closer to home.

An opportunity to bridge the primary/secondary care interface, resulting in more streamlined services to enhance the patient experience.

The opportunity to access complete patient records with patient consent, thus enabling optimum patient-centred management.

Opportunities for building one-to-one trusting relationships with each patient through counselling, education and a pharmaceutical care approach to medication-related issues, resulting in patient empowerment and satisfaction.

Opportunities to collaborate with other healthcare professionals, allowing cultivation of effective multidisciplinary working to enhance the patient experience and support patients with long-term conditions.

In the long term, PhwSI accreditation provides greater security, if service level agreements specify PhwSI.

Further information

NHS Primary Care Commissioning. For news, competency frameworks, template portfolios, assessments and personal development tools go to www.pcc.nhs.uk/119

Becoming a PhwSI

Consider special interest accreditation, say **Linda Hirst** and **Marta Hildebrandt** – it's well worth the effort

What is a Pharmacist with Special Interest (PhwSI)? The Department of Health's (DH's) definition is: "A PhwSI supplements their core generalist role by delivering an additional high quality service to meet the needs of patients.

"Working principally in the community, they deliver a clinical service beyond the scope of their core professional role or may undertake advanced interventions not normally undertaken by their peers. They will have demonstrated appropriate skills and competencies to deliver those services without direct supervision."

The key points are:

A PhwSI has undergone an accreditation process relating specifically to a particular clinical service. This is different to a qualification.

The clinical service has to be over and above the pharmacist's core role and is usually a service that improves patient's access to care.

The accreditation process ensures the pharmacists have the skills and competencies to deliver the service.

Do I need to be a supplementary or independent prescriber first?

It is not a requirement for a PhwSI to be qualified as a prescriber. However, the DH does say, "in practice, this may enhance the scope of the role".

Where do I start?

The DH advises pharmacists to firstly find out whether local decision-makers are planning to commission specific services through PhwSIs. If in principle they are, you will need to match your clinical interest and skills to any proposed local service, investigate how that service is likely to be commissioned and determine whether the PhwSI accreditation would be an acceptable quality marker.

How do I become accredited?

The next step would be to address the competency frameworks. There are national guidelines for accreditation of PhwSI but most localities develop their own, based on the national model. Additionally, some specialities such as anticoagulation now have their own specific frameworks.

You will need to compile a portfolio of evidence to submit to the commissioners for approval and subsequently meet with the "accreditation panel" for discussion.

What should my portfolio include?

It must include details of:

- the service and its location
- referral criteria
- integrated patient pathway
- collaboration
- education, training and development
- clinical quality and governance – measurement for improvement
- clinical support
- resuscitation certificate
- indemnity arrangements.

If the accreditation panel decide the applicant has the necessary competences to fulfil the role, accreditation is given, specifying the length of time before re-accreditation must take place. This is usually a maximum of three years.

How much does it cost?

There is no cost for accreditation, but you will need adequate professional indemnity assurance.

What next?

Once accreditation has been given and the service is up and running, there is still work to be done. Clinical audit is a key feature and the commissioners will require ongoing evidence of a quality service. CPD is vital, as is evidence of clinical networking; and, of course, feedback from patients is essential.

Linda Hirst and Marta Hildebrandt were the first pharmacists in England to be accredited as PhwSIs

PhwSIs Marta Hildebrandt, left, and Linda Hirst provide anticoagulation monitoring services at a weekly clinic in Wilsden Medical Practice, Bradford

Case study – Linda Hirst

For me, becoming a PhwSI wasn't so much an inspired decision as a case of being in the right place at the right time. Our PCT wanted pharmacists to train in anti-coagulation in order to run clinics in GP surgeries. We trained, set up the clinics and gradually built up the number of patients.

As time went by we needed to expand and reassess the future of our clinic. The PCT decided the best way forward was as a practice-based commissioned service, and it then became a condition of the PCTs' acceptance of the service that we were accredited as PhwSIs.

My colleague and I wondered if we really wanted to put ourselves through this, but with practice and experience there is a massive amount of satisfaction in running a service like this, particularly because the patients love it and it's professionally satisfying to be so engaged with the whole primary care team. We have found a niche for ourselves, so becoming a PhwSI has been very worthwhile.

We have had steep learning curves, dealing with clinical issues that would previously not have been within our remit, and feeling so responsible for patients' wellbeing.

If we can do it, anybody can! It just takes enthusiasm, hard work – and excellent support from the GP practice and the PCT.

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Contact: Andrew Walker
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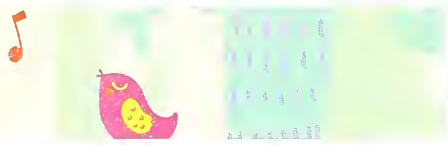
Postscript...



C+D's week in tweets

@CandDChris: Big thanks to Lloydspharmacy pharmacist who spotted a relative was prescribed an inappropriate dose. Good job!

@CandDJennifer: Wondering how pharmacy is going to react to a study which says partial relaxation of control of entry has had "significant benefits"...

@CandDZoe: Hearing that some manufacturers are still asking for scripts to be faxed before supplying... anyone had any problems?

Last week's top stories on C+D's website

1. Jail fear remains as dispensing error review 'under consideration'
2. Update 1519: Managing patients on warfarin
3. Lloydspharmacy calls for solution to ethics-contract conflict

Marathon men

It's only three weeks until the London Marathon, and a host of runners from across the sector are getting their training shoes on in preparation for the 26-mile slog.

Rowlands Pharmacy managing director Kenny Black will be jostling somewhere in the crowds of nuns, pantomime horses and less serious runners to raise funds for the NSPCC's Child's Voice Appeal. He will be joined by BAPW executive director Martin Sawer, who will be running on behalf of the Juvenile Diabetes Research Foundation.

And Beta Pharmaceuticals' charitable trust will also be busy on April 25 – the date is also the WHO's World Malaria Day – and plans to donate funds raised in the marathon to various initiatives to help tackle malaria.

To donate to these worthy causes, go to **www.justgiving.com/kenny-black** or **/martin-sawer**, or visit **www.betacharitabletrust.org**.

C+D Reader of the week

Leena Kohli from East Bolden Village Pharmacy talks sunshine, toilet-stopping medicines and bacon sandwiches

What would be your ideal holiday destination? The Caribbean. I got married in the Bahamas and I'm a real sunshine person.

Why did you become a pharmacist? I fell into it really – I got into the sciences and I liked working with people so this was a way to balance the two.

What would you be if you weren't a pharmacist? A food critic! I'm a real foodie and I love cooking.

So what do you eat for breakfast? I don't actually eat breakfast, and even lunch is just a boring sandwich crammed in between scripts.

What's the weirdest request you've ever had from a patient? One man said he was going to a festival and he wanted something to stop him needing to go to the toilet while he was there.

What pharmacy service would you most like to see rolled out nationally? A minor ailments service.

What do you do to switch off? I like to go to the pictures and watch films. I've just been to see Alice in Wonderland, which was good, and I liked the special effects in Avatar.

What question should we ask the next interviewee? If you have a bacon sandwich, do you have it with ketchup or brown sauce?

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk

The Victorian Pharmacist

"Like all creatures of low organisation, it is wonderfully tenacious of life. When one head is cut off, another is developed"

Sir,

The United Society of Chemists and Druggists seems to have as many lives as a cat. In the course of its eventful history it has been brought to death's door by atrophy, by internal disorders, and by the malpractice of its physicians. Yet it still lives.

I really thought it had died from the effects of recent convulsions, and there was nothing left but to bury it decently. I was mistaken. Like all creatures of low organisation, it is wonderfully tenacious of life. When one head is cut off, another is developed, and the mischief resulting from disruption is rapidly repaired.

I am reluctant to report that Mr Cyrus Buott has formed a new Executive Committee, and has induced Mr J.T. Slugg to become its president.

With this "scratch company", the energetic manager will doubtless produce a new sensational drama at the earliest opportunity. But seeing as there is now no Benevolent Fund, and that the Pharmacy Act 1868 has now been passed, I fear he will have some difficulty in hitting upon a good plot.

We may be quite sure, however, that there will be abundant talk, if but little action, in the new piece, and that there will be no lack of thunder.

Last year, Postscript said it would let you know what happened to C+D's creation, the United Society of Chemists and Druggists, which was founded in 1860. Well, the Victorian Pharmacist's comments are based C+D's editorial from October 1868 and – from the sound of it – C+D wasn't a fan any more. The Victorian Pharmacist will keep his beady eye out for any further mentions of the alternative Society in our archives.

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Alastair Buxton
Head of NHS Services, PSNC

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NiQuitin Minis Mint 1.5mg/4mg Lozenges (nicotine). Indication: smoking cessation. **Dosage: Adults (18 and over):** One lozenge (max. 15/day, dependent upon how to smoke to aid complete cessation (taper use after 6 weeks) or gradual cessation (seek advice if no reduction after 6 weeks of gradual cessation (seek advice if no reduction after 6 weeks of gradual attempt after 6 months). Professional advice if use >3 months. Use 4mg strength if smoke ≤20/day, if nervous of dependence. **Adolescents (12-17 years):** Abrupt cessation only. Dosing as for adults. Seek professional advice if >12 weeks treatment required. **Contraindications:** Hypersensitivity. Non-smokers, children under 12 years. **Precautions:** Risk of NRT substantially outweighed by risks of continued smoking in virtually all circumstances. Supervise use in those hospitalised for MI, severe dysrhythmia or CVA who are haemodynamically unstable. Once discharged, can use NiQuitin as normal. Susceptibility to angioedema, urticaria. Discontinue use if severe/persistent GI discomfort, vomiting, diarrhoea, dyspepsia, fatigue, malaise, chest pain, oral irritation, dizziness, headache, sleep disorders including abnormal dreams, anxiety, irritability, nervousness, depression, palpitations, increased heart rate, cough, sore throat, rash, anaphylaxis. See SPC for full details. GSL. **PL** 00079/0610, 0611. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack sizes and RSP (excl. VAT):** 20's £4.75, 60's £13.32. **Date of revision:** August 2009.

NiQuitin 21, 14, 7mg Transdermal Patches, NiQuitin Clear 21, 14, 7mg (nicotine). Opaque or transparent transdermal patches 21mg, 14mg, 7mg nicotine (Steps 1, 2, 3) for relief of nicotine withdrawal symptoms during smoking cessation. **Dosage: Adults (18 and over):** ≥10 cigarettes/day: Step 1 for 6 weeks, then Step 2 for 2 weeks, then Step 3 for 2 weeks. <10 cigarettes/day: Step 2 for 6 weeks then Step 3 for 2 weeks. Apply to fresh site (clean, dry skin) once daily. Professional advice if use >3 months. **Adolescents (12-17 years):** As for adults but to seek professional advice if >12 weeks treatment required. **Contraindications:** Hypersensitivity, occasional/non-smokers, children under 12 years. **Precautions:** Risk of NRT substantially outweighed by risks of continued smoking in virtually all circumstances. Supervise use in those hospitalised for MI, severe dysrhythmia or CVA who are haemodynamically unstable. Once discharged, can use NiQuitin as normal. Susceptibility to angioedema, urticaria. Discontinue use if severe/persistent skin reactions. Renal/hepatic impairment, hyperthyroidism, diabetes, phaeochromocytoma. **Pregnancy/lactation:** For those unable to quit unaided the risk of continued smoking is greater than the risk of using NRT. Start treatment as early as possible in pregnancy for 2-3 months. Lozenge/gum preferable to patches unless nauseous. Remove patches at bedtime. **Side effects:** At recommended doses, NiQuitin patches have not been found to cause any serious adverse effects. Local rash, itching, burning, tingling, numbness, swelling, pain, urticaria, heaviness, hypersensitivity reactions. Headache, dizziness, tremor, sleep disorders, nervousness, palpitations, tachycardia, dyspnoea, pharyngitis, cough, GI disturbance, sweating, arthralgia, myalgia, malaise, anaphylaxis. See SPC for full details. GSL. **PL** 00079/0368, 0367, 0366, 0356, 0355 & 0354. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack sizes and RSP (excl. VAT):** 7 patches £14.89; Step 1 only 14 patches £28.04. **Date of revision:** August 2009. **NiQuitin®, NiQuitin® Minis** and the **Minis Device** are trademarks of the GlaxoSmithKline group of companies

Reference: 1. National Institute for Health and Clinical Excellence. Smoking cessation services in primary care, pharmacies, local authorities and work places, particularly for manual working groups, pregnant women and hard to reach communities. Public Health Guidance 10. February 2008.

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